The information on this form is not part of any acceptance process for students or staff, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Recommendations of Licensed Medical Personnel", <u>is to be filled in completely by parents/guardians of minors or by adults themselves.</u>

Name: _____ **Date of Birth:**_____
Last **First** **Month/Day/Year**

Home Address: _____
Street Address **City/State/Zip**

Student's Social Security Number: _____ **Gender: Male** ____ **Female** ____

Custodial Parent/Guardian: _____**Telephone: ( ) _____**

Home Address (if different from above):
_____
Street Address **City/State/Zip**

Business Phone: ( ) _____ Cell Phone: ( ) _____ Home Phone: ( ) _____

We should try contacting you first at the ____Business _____Cell _____Home.

Second Parent or Guardian Emergency Contact: _____**Relationship:**_____

Address: _____**Phone: ( )**_____

Business Address: _____**Phone: ( ) _____**

If neither of above is available, in an emergency notify:

Name: _____***Phone: ( )***_____

Relationship: _____***Cell Phone: ( )***_____

Address: _____

INSURANCE INFORMATION:
Is the participant covered by family medical/hospital insurance? Yes____ No ____

If so, indicate carrier or plan name: _____**-Group #** _____

Carrier's Address:

_____

Name of insured:_____**Relationship to participant:**_____

Social Security Number of policyholder or insurance ID number: _____

IMPORTANT!!! This box must be completed for attendance

<u>*Permission to Provide Necessary Treatment or Emergency Care:</u>
I hereby give permission to the medical personnel selected by camp or program director to order X-rays; routine tests; treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by SCDNR or its representatives to secure and administer treatment including hospitalization for the person named above. This completed form may be photocopied for trips out of camp.

Signature of parent or guardian or adult staffer: _____**Print Name:** _____

Witness: _____ **Print Name:** _____ **Date:** _____

*If for religious reasons you cannot sign this form, contact Program Coordinator, for a legal waiver, which must be signed for attendance.

HEALTH HISTORY

The parent/guardian, or adult staff member must fill in the following information. The intent of this information is to provide camp or program health care personnel the background to provide adequate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp or program health care personnel upon participant's arrival on site. Provide complete information so that the camp can be aware of your needs.

ALLERGIES **List all Known.** **Describe reaction and management of the reaction.**

_____
_____
_____
_____

Food Allergies: (List)

_____
_____
_____
_____

Other Allergies: (List)

_____
_____
_____
_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time of camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, dosage, and frequency of administration.

_____ **This person takes NO medications on a routine basis. (Initial if applicable)**

_____This person takes medications as follows:

Med #1_____ Dosage: _____Specific times taken each day _____

Reason for taking _____

Med #2_____ Dosage: _____Specific times taken each day _____

Reason for taking _____

Med #3_____ Dosage: _____Specific times taken each day _____

Reason for taking _____

Attach additional pages if necessary.

RESTRICTIONS

The following restrictions apply to this individual:

Dietary: ☐ **Does not eat red meat** ☐ **Does not eat pork** ☐ **Does not eat eggs** ☐ **Does not eat poultry**
☐ **Does not eat seafood** ☐ **Does not eat dairy products** ☐ **Other (describe)** _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary):

_____
_____
_____
_____
_____
_____
_____
_____

GENERAL QUESTIONS: (Explain "Yes" answers below.)

Has/does the participant:

1. **Had any recent injury, illness or infectious disease?** ☐ Yes ☐ No
2. **Have a chronic or recurring illness/condition?** ☐ Yes ☐ No
3. **Ever been hospitalized?** ☐ Yes ☐ No
4. **Ever had surgery?** ☐ Yes ☐ No
5. **Have frequent headaches?** ☐ Yes ☐ No
6. **Ever had a head injury?** ☐ Yes ☐ No
7. **Ever been knocked unconscious?** ☐ Yes ☐ No
8. **Wear glasses, contacts or prescriptive eyewear?** ☐ Yes ☐ No
9. **Frequent ear infections?** ☐ Yes ☐ No
10. **Ever passed out during or after exercise?** ☐ Yes ☐ No
11. **Ever had seizures?** ☐ Yes ☐ No
12. **Ever had chest pain during or after exercise?** ☐ Yes ☐ No
13. **Ever had high blood pressure?** ☐ Yes ☐ No
14. **Ever been diagnosed with a heart murmur?** ☐ Yes ☐ No
15. **Have diabetes?** ☐ Yes ☐ No
16. **Have asthma?** ☐ Yes ☐ No
17. **Had mononucleosis in the past twelve months?** ☐ Yes ☐ No
18. **Ever had an eating disorder?** ☐ Yes ☐ No

Please explain any "yes" answers, noting the question numbers: _____
_____
_____
_____
_____
_____
_____

Date of last Tetanus vaccine: _____ **Are other immunizations current?:** _____

Use this space to provide any additional information about the participant's health (mental, emotional and/or physical), which the camp/program director should be aware of: _____
_____
_____
_____
_____
_____

Name of family physician: _____**Phone: ( )** _____

Address: _____

PARENT/GUARDIAN AUTHORIZATIONS: This health history is correct and complete as far as I know, and the person herein has my permission to engage in all camp/program activities except as noted.

_____

_____

Signed: _____Print Name: _____

Witness: _____ Date: _____